

CENTERS FOR MEDICARE & MEDICAID SERVICES  
Special Open Door Forum:  
Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport  
September 15, 2014  
1:00 p.m. ET

Operator: Good afternoon. My name is (Stephanie) and I will be your conference operator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum, Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Stephanie). Welcome everyone. My name is Jill Darling; I'm in the CMS Office of Communications. And thank you for you joining today's Special Open Door Forum.

So, I'll pass this over to Connie Leonard who is the provider compliant – who is – excuse me, who is part of the Provider Compliance Group.

Connie Leonard: Thank you, Jill.

Welcome everyone. This is our second special open door forum that we are having on the Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transports.

My name is Connie Leonard. I'm the deputy director of the Provider Compliance Group, which is in the Office of Financial Management in CMS, and we are responsible for this model.

Today, we had a call about a month ago and so we got a lot of great questions. And so today, we are hoping to clarify some of those questions. We are announcing the start date, and we also try to clarify who is going to be impacted by the model.

And with that, I'll turn it over to Jennifer McMullen for the slide presentation.

Jennifer McMullen: Thank you.

The purpose of this model is to establish a three-year prior authorization process for repetitive scheduled non-emergent ambulance transport, and to ensure that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payments to protect the Medicare trust fund by granting provisional affirmation for a service prior to submission of the claim.

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before a service is rendered to a beneficiary and before a claim is submitted for payment. Prior authorization helps ensure that applicable coverage, payment and coding rules are met before services are rendered. Some insurance companies, such as TRICARE, certain Medicaid programs, and the private sector, already use prior authorization to ensure proper payment before the service is rendered.

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period, or at least once per week for at least three weeks. Repetitive ambulance services are often needed by beneficiaries receiving dialysis, wound or cancer treatment.

Who and what are included? Ambulance suppliers that are not institutionally based, that provide Part B Medicare covered ambulance services, and are enrolled as an independent ambulance supplier are included in this model.

Hospital-based ambulance providers which are owned and or operated by a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home-health agency, or hospice program are not included in this model.

Repetitive scheduled non-emergent ambulance transport claims billed on a CMS-1500 Form and or a HIPAA compliant ANSI X12N 837P electronic transaction are included. Ambulance transports not included – include all ambulance transports included in a covered Part A stay, and all transports provided by an institutionally-based ambulance provider.

Where and when? MACs will tentatively begin accepting prior authorization requests in South Carolina on October 30th, 2014 for repetitive scheduled non-emergent ambulance transport scheduled to occur on or after November 15, 2014.

All repetitive scheduled non-emergent ambulance transports with a date of service on or after November 15th, 2014 must have completed the prior authorization process or the claims will be stopped for prepayment review.

In New Jersey and Pennsylvania, MACs tentatively will begin accepting prior authorization requests on December 1st, 2014 for repetitive scheduled non-emergent ambulance transports scheduled to occur on or after December 15th, 2014.

All repetitive scheduled non-emergent ambulance transports with a date of service on or after December 15th, 2014 must have completed the prior authorization process or the claims will be stopped for prepayment review.

Ambulance location is based on where the ambulance is garaged.

The following ambulance HCPCS codes are subject to prior authorization. A0425 BLS/ALS mileage, A0426, ambulance service, advanced life support, non-emergency transport, level one, and A0428, ambulance service, basic life support, non-emergency transport.

No prior authorization decisions will be made on any code not on this list. If an A/B MAC receives a prior authorization request for a code not on this list, the MAC will not review the request and will not issue a decision letter.

The medical necessity requirements for Medicare coverage of ambulance services are set forth in 42 CFR Section 10.40d. Medicare covers ambulance services, including air ambulance, fixed wing and rotary wing, when furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

Medicare coverage policies are unchanged under this model. Documentation requirements are also unchanged. And timeframes for transports are unchanged as well.

The model does not create any new documentation requirements. It simply requires the information to be submitted earlier in the claims process. Current requirements can be found on the A/B MAC Web sites.

Also unchanged are the A/B MACs that will conduct the reviews, all Advance Beneficiary Notice policies, claim appeal rights, dual eligible coverage and private insurance coverage.

What has changed? The ambulance supplier will know before the service is rendered whether Medicare will pay for the service. Upon request, the beneficiary will be notified before the service is rendered whether Medicare will pay for the service.

As of September 15th, 2014, the prior authorization request needs to identify the beneficiary's name, Medicare number, date of birth and gender, the certifying physician's name, National Provider Identifier, PTAN and address, the ambulance supplier's name, the NPI, PTAN and address, the requestor's name and telephone number, procedure codes, submission date, start of the 60-day period, state where the ambulance is garaged, and must indicate if the request is initial or subsequent review, and indicate if the request is expedited and the reason why.

The request also needs to include the Physician Certification Statement, number of transports requested, documentation from the medical record to support the medical necessity of repetitive scheduled non-emergent ambulance transport, information on the origin and destination of the transports, and any other relevant documentation as deemed necessary by the contractor to process the prior authorization.

The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips, which equates to 80 trips, per prior authorization request in a 60-day period. A provisional affirmative prior authorization decision may affirm less than 40 round trips, or affirm a request that seeks to provide a specified number of transports, 40 round trips or less, in less than a 60-day period.

An affirmative decision can be for all or part of the requested number of trips. Transports exceeding 40 round trips or 80 one-way trips in a 60-day period require an additional prior authorization request.

The ambulance supplier or the beneficiary may submit the request. The request can be mailed, faxed, submitted through the MAC provider portal when available, or submitted to the Electronic Submission of Medical Documentation, esMD System.

For initial requests, the A/B MAC makes every effort to review requests and postmark decision letters within 10 business days. For subsequent requests, the A/B MAC makes every effort to review the request and postmark decision letters within 20 business days. In expedited circumstances, the A/B MAC will make reasonable efforts to communicate a decision within two business days of receipt of all applicable Medicare required documentation.

Decision letters are sent to ambulance suppliers and beneficiaries upon request. Decision letters include the prior authorization unique tracking number that must be submitted on the claim. Decision letters that do not affirm the prior authorization request will provide a detailed written explanation outlining which specific policy requirements were not met.

The Medicare A/B MAC will list the prior authorization unique tracking number on the decision letter. This tracking number must be submitted on the claim. When submitting electronic 837 professional claims, the unique tracking number can be submitted in either the 2300 Claim Information Loop or 2400 Service Line loop in the prior authorization reference segment, where REF01 equals G1 qualifier and REF02 equals UTN. This is in accordance with the requirements of the ASC X12 837 Technical Report three.

When submitting a paper CMS-1500 Claim Form, the unique tracking number must populate the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15.

When a prior authorization request is submitted but non-affirmed, a submitter can resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request, or provide a service and submit a claim. The claim will be denied and all appeal rights are available.

For non-affirmed prior authorization requests, unlimited resubmissions are allowed. These requests are not considered appeals. For denied claims, all normal appeal rights apply.

If prior authorization is not requested before the fourth round trip, the subsequent claims will be stopped for prepayment review. The A/B MAC sends additional request letter and waits 45 days for a response. And then, excuse me; the A/B MAC reviews submitted documentation within 60 days. Without a prior authorization decision, the supplier or the beneficiary will not know whether Medicare will pay for the service and the supplier or beneficiary may be financially liable.

CMS strongly encourages ambulance suppliers to use the Medicare prior authorization process.

The following are a few scenarios. If prior authorization is requested, and the A/B MAC decision is affirmative, the supplier should submit a claim, and the claim will be paid as long as all other requirements are met.

If a prior authorization request is submitted, and the A/B MAC decision is non-affirmative, the supplier can submit a claim, and the A/B MAC will deny the claim, or the supplier can fix and resubmit the prior authorization request.

If prior authorization request is not submitted, the A/B MAC does not make a decision, and the supplier submits a claim. The A/B MAC will then develop the claim and conducts prepay review.

The service benefit is not changing. And beneficiaries, upon request, will receive a notification of the decision about their prior authorization request. Dual eligible coverage is not changing. And private insurance coverage is not changing.

References on services from the A/B MAC can be found on the A/B MAC Web site. In New Jersey and Pennsylvania, this is Jurisdiction JL Novitas. And in South Carolina, this is Jurisdiction J11, Palmetto GBA Columbia.

More information can be found on the model Web site, at <http://go.cms.gov/PAAmbulance>. And on the Web site can be found fact sheets, frequently asked questions, background information, information on open door forums, and soon, an operational guide.

For more information, please e-mail the prior authorization team at [AmbulancePA@cms.hhs.gov](mailto:AmbulancePA@cms.hhs.gov), or visit the model Web site at <http://go.cms.gov/PAAmbulance>.

Thank you.

And now, I'd like to turn it back over to Connie Leonard.

Connie Leonard: Thank you, Jennifer.

The slides that Jennifer just used to present, as well as an updated Frequently Asked Question document, will be on the Web site that Jennifer just mentioned hopefully later today.

The slide presentation that is there right now is from a previous open door forum, so it's very similar to the one that was used, as well as the Q&A

document, except the updated version, will have a few new questions based on our last open door forum.

So today, you learned a few new things from the last open door forum. First, you learned that CMS will begin the open door – the open door forum – that we will begin the prior authorization model in the State of South Carolina. And that suppliers will tentatively be able to begin submitting prior authorization requests on October 30th, with dates of service, November 15th and beyond.

And then in New Jersey and Pennsylvania, the same thing will tentatively happen December 1st; suppliers will be able to begin submitting the prior authorization request for dates of service on or after December 15th, 2014.

We also tried to clarify who was impacted. That was a lot of the questions we received last time. If you – if the hospital – if the ambulance company is owned by a hospital, it is not included in this prior authorization model. It is only those ambulance suppliers that are independent and have billed Medicare Part B independently that are impacted by this model.

All other requests will not be answered or received by the MAC.

The MAC – those are the MACs, Novitas and Palmetto GBA, will be conducting education in their various jurisdictions in the near future. So that will be something that will, again, give you guy's specific information about your very specific jurisdictions.

As Jennifer mentioned, we hope to have an implementation guide out very soon. I expect it to be on the Web site in the mid-October timeframe. This implementation guideline will take the supplier all the way through the process to give detailed information about what the supplier needs to do and what the suppliers' responsibilities are and what the MAC's responsibilities are.

One of the common questions we get is, does this prior authorization request save or protect the supplier from review by another entity? And it will, in some cases, the prior authorization request and that claim and the series of



claims for that beneficiary for that time period, will not be reviewed by recovery auditor or the MAC proposed payment review. However, it is possible that a zone program integrity contractor or ZPIC could come along at a later time and still review this claim from a potential fraud investigation perspective.

And if there are suppliers out there that are currently undergoing 100 percent, which means all of your claims are reviewed, 100 percent prepayment review by a ZPIC today, and that 100 percent review is still ongoing when we begin the prioritization model, you will not be able to submit claims into the prior authorization model. And the MAC will send those back to you with that rationale that you're already under review by another entity.

So that's going to be very important that if you're already under review by the ZPIC, you're not going to be able to participate this time. Now, if that review closes, there may be come a period time when you are available to participate.

Lastly, the last issue that we have is there may come a time when a beneficiary changes their supplier. So there needs to be some sort of transfer. And the prior authorization request; while they are by bene – by the beneficiary; they do not follow the beneficiary.

So, if the supplier changes, a new prior authorization request will be required. And only one prior authorization request can be approved at one time for one 60-day period of time.

So, if there is a change in between, the MAC will have to get notification or the second prior authorization request will be denied. And all of these claims will need to conduct pre-payment with – they will conduct prepayment review on.

And we'll have more information about that in the implementation guide, exactly what needs to happen in the event there is a transfer of a supplier.

And with that, I would like to turn it open to questions.

Operator: And as a reminder, ladies and gentlemen, if you would like to ask a question, please press star one on your telephone keypad.

If you would like to withdraw your question, press the pound key.

Please also limit your questions to one question and one follow up to allow other participants time to question.

If you require any further follow up, you may press star one again to rejoin the queue.

And your first question comes from the line of (Susan Delos Andrew) from On Time Ambulance. Your line is open.

(Susan Delos Andrew): Hi. I was just – the last time I had listened in, there were questions regarding whether or not you're going to require prior authorization from patients that are currently residing in facilities that are taken for either radiation wound care or dialysis. There was a little bit of, I thought, ambiguity. I wasn't clear.

Connie Leonard: Correct. You're actually correct. There was some confusion last time. And so that is why we have tried to clarify in today's meeting that if that facility to facility transfer or they're going from a skilled nurse facility to the dialysis treatment center, or wherever the transport may be taking them.

If that ambulance transfer is included in that Part A payment, then it's not impacted by the model, or if it's the ambulance from a Part A perspective, but if that ambulance transfer is happening by an independent ambulance supplier and that ambulance supplier is billing Medicare Part B for the services, that it is included in the model.

(Susan Delos Andrew): OK. OK. Thank you. Thank you for the clarification.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Adam Pott) from O'Connor Medical Center. Your line is open.

(Adam Pott): My question was if the hospital-based provider transported a new patient that has had the preauthorization otherwise, is there any action we need to take as we are not included in the model?

Connie Leonard: No, there would be no action that you would have to take because those claims that you've submitted would not be included in the model and would not be stopped for prepayment review under the model.

(Adam Pott): OK. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Andrea McKay Bradley) of (Wilbert Court). Your line is open.

(Andrea McKay Bradley): I'm sorry. I just wanted to clarify. I know that we got started on the line pretty quickly here, but it was a lot of information from the first speaker. I didn't quite hear whether or not that would be recorded to send to us again because it was a lot of information. Is that going to be sent to us again?

Connie Leonard: Are you asking if the special open door forum will be recorded and the transcript is out on the Web site?

(Kate McKay Bradley): Right, for further review because I'm not sure that I've captured everything. It was a lot of information.

Connie Leonard: Yes. The recording and transcripts will be posted to the special open door forum Web site. Usually takes about a week or so, but they will be out there.

And then as I did mention, hopefully by the – before close of business today, the updated slides as well as the updated Frequently Asked Question document will be out on the prior authorization Web site. And I think you'll find that helpful, too.

(Andrea McKay Bradley): So that Web site is where I wasn't clear and she went through quickly, it's the go something.

Connie Leonard: Sure. I'm going to repeat one more time. It's go.cms.gov, G-O-V, slash P as in (Paul), A as in (Andy), and then the word ambulance.

(Andrea McKay Brandley): I think that kind of do it. And then my next question, you said they're going to kick these changes in, in December, right?

Connie Leonard: If you are in the State of New Jersey or Pennsylvania, then the tentative effective date for you or for suppliers in those areas would be December 15th, that is correct.

(Andrea McKay Bradley): December 15th. Where in South Carolina?

Connie Leonard: In South Carolina, it is tentatively dates of service, November 15th and beyond. You can begin submitting those on October 30th.

(Andrea McKay Bradley): OK.

Now, I have one question and then I'm going to release you back to your conference. I want to know – I know we're not going to get all of this right at once. I know it's a learning curve. Are we going to have a way to be assisted if we make a mess of it, initially, we're trying not to.

Connie Leonard: No. And we appreciate you being proactive in trying to set up an internal practice, but you're absolutely right. This is something that is totally new. And the MAC expects a certain amount of errors and they will be working with the suppliers, and that is why you can have another submission of the prior authorization request. We've seen this historically when we completed the prior authorization for power mobility devices.

In the beginning, there were lots of confusions in what documents do I need to submit, but then our suppliers learned it very quickly. We expect the same will happen here as to what documentation needs to be provided.

And so the MACs will be there to assist and you can resubmit those documents. And even though they have up to 20 days to complete the reviews on these resubmissions, historically speaking, they would not take that long in

the power mobility device demonstration. So I do not expect the same to occur here.

We believe that while it may be tough in the beginning as suppliers are learning this new process, suppliers learn very quickly and you know after a month or two, a few resubmissions, then everything is going to go a lot more smoothly than in the beginning.

(Andrea McKay Bradley): So the practice will come to...

Connie Leonard: So you're taking that proactive step.

(Andrea McKay Bradley): So the practice will come to – we call in the prior authorization, they will ask us what information for the transport needs, and then we'll hear back from the provider...

Connie Leonard: No, what actually will happen is – so Medicare's prior authorization is probably different than what you may experience with other insurers. And so there's no calling in of the information.

You actually submit all of the documentations to your MAC and then the MAC will issue you a response back.

And that is why the first three round trips are not prior – do not have to be prior authorized or do not get pulled or chosen for prepayment review. It allows that transportation to continue while the supplier is getting their documentation in.

But we would stress that supplier that are – that has beneficiaries right now that are enrolled in Medicare and they need this repetitive schedule of non-emergent ambulance transport, you're doing it today. You know you're still going to be doing that for a subset of your beneficiaries when it comes to November.

You know that is why we're giving this two week period of time for you to go ahead and get all your existing beneficiaries in to your MAC so you can get those prior authorized and, hopefully, that'll help you and the MAC when it

comes to the tentative November 15th date as you're getting new requests in the door.

(Andrea McKay Bradley): OK. And I'm sorry for being totally oblivious. I'm sorry. But the MAC – and a number for the MAC will be submitted to us?

Connie Leonard: I didn't hear the last part of your question. I'm sorry.

(Andrea McKay Bradley): The MAC stands for what – and the number of the MAC will be submitted to us.

Connie Leonard: The MAC is the Medicare Administrative Contractor, and we will make sure we have contact information in the implementation guide so that you know to reach to.

And our e-mail address is ambulance and then [pa@cms.hhs.gov](mailto:pa@cms.hhs.gov). And if you want to e-mail that box, we can make sure that you're on the list through South Carolina so that you know of all the educational efforts that Palmetto GBA is going to do.

(Andrea McKay Bradley): OK. Can you give me a phone number because I don't think I got it all down right?

Connie Leonard: We'll make sure we have the phone number out there for Palmetto, too. But if you can e-mail us in that box, then we can make sure that you get in touch with the MAC. You can get all the required information that you need for your supplier, OK?

(Andrea McKay Bradley): Thank you. I'll do it. I'll leave you alone.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (Denise Heminin) from Empire Ambulance. Your line is open.

Female: (inaudible).

(Denise Heminin): Hello?

Connie Leonard: Hello? Yes.

(Denise Heminin): Yes. I'm sorry.

I would just – my question is, does it still – and I really didn't get the first question. But it's just still the – or do we still need a prior authorization from residence only or from the skilled nursing facility when they have multi-trips?

Connie Leonard: It actually depends on who is billing for that ambulance service. So if it is an independent ambulance supplier and that ambulance supplier is billing Medicare Part B for these services, that it is included in the model.

If that ambulance company is owned by the facility, it's a hospital-based or a facility-based ambulance company, then; it is not included because they would be going Part A. So it really comes down to, how is the ambulance services being billed and if they're being billed to Medicare on a – through the Part B services and the 11500 form, it's included in the model.

(Denise Heminin): OK.

And once we get – I just want to make sure, for the prior authorizations, you say for New Jersey, starts on December 15th. From what dated of service are we supposed to get the prior authorization for?

Connie Leonard: It is tentatively for all date of service, December 15th and beyond. And so it's a three-year demonstration. So, this demonstration would go through December 15th, 2017 in the states of New Jersey and Pennsylvania.

(Denise Heminin): OK.

Connie Leonard: Go ahead.

(Denise Heminin): Go ahead.

Connie Leonard: I was just going to say, the tentative December 1st date is the date for suppliers in Pennsylvania and New Jersey can go ahead and submit current beneficiary prior authorization request, so that when December 15th gets here,

you don't have to submit and the MAC has been getting over – being overwhelmed by all of these requests from current beneficiaries.

So if you have someone that you know is going to be needing repetitive schedule non-emergent transport, you know, in December, then as of tentatively December 1st, you can go ahead and submit those requests for date of service, December 15th and beyond.

When the affirmation was received, it would be from 60 days from that point. And then I – we suspect that there will be, you know, beneficiaries who you will develop an internal process so that, you know, every 45 days, you're submitting that request. So that if they continue this prior authorization for beneficiaries, that you don't need to care for more than one 60-day time period.

(Denise Heminin):OK. I just want to make this clear. So you're letting me know that our current patients that we have, we should start by December 1st getting the prior authorization.

Connie Leonard: Yes. I believe...

(Denise Heminin):OK.

Connie Leonard: ... we believe that would help those – the supplier and the MAC if those current beneficiaries are submitted as of December 1st. And so that way you don't – you may already have the prior authorization request and then you won't have to submit current as well as any new prior authorization request on December 15th.

(Denise Heminin):Oh, OK, then. All right then.

There's one more question, I'm sorry. How advance should we get the prior authorization so that by the time we give the transportation itself in the service – get the prior authorization like how soon, how advance should we get it?

Connie Leonard: My suggestion would be, obviously, once we begin the model that as soon as you get notification that you're going to be providing services to a beneficiary,



I would submit the prior authorization request, obviously, you have to have all the documentation.

And I know that that's working with the appropriate physicians to get everything that you need to get the request in. But I would submit it as soon as you know and have all the documentation because after the third round trip, those claims for that beneficiary are going to be flagged for prepayment review.

And prepayment review will take more time than submitting the prior authorization request does. So it's going to be very important for our suppliers to develop a process so that as soon as they get notification, they're getting all the documentation they need and it can get submitted.

In ideal situation, you'll have your approval back before you go to do that for a transport and then you, the supplier, will know that the claims are paid. The beneficiary will know and you won't run into issues with a large number of prepayment reviews that could impact your cash flow.

(Denise Heminin): OK. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (Pamela Patrick) from Stony Brook University. Your line is open.

(Pamela Patrick): Good morning.

We frequently transport patients from our hospital to a nearby skilled nursing facility. And we are billing this with modifier H for Harry, E for echo, and we are getting these claims denied due to lack of medical necessity for the ambulance transport. My question is, are – should we be requiring an ABN on that? And how do we know if it's going to be medically necessary or not?

Connie Leonard: Well, you cannot just require an ABN in all services, but I would suggest if you send in a little bit more information to that e-mail box, then we can actually work with the policy staff to get you an answer.

(Pamela Patrick): OK.

Connie Leonard: Do you need the e-mail address?

(Pamela Patrick): That's the [AmbulancePA@cms.hhs.gov](mailto:AmbulancePA@cms.hhs.gov) ?

Connie Leonard: You got it, yes. So if you send just a little bit more information, then we can work with the policy group or the MAC for you, if we need to, just to provide you with some more information so that you'll be able to get those – all the necessary documentation in the record.

(Pamela Patrick): OK. What kind of more details are you looking for?

Connie Leonard: We certainly do not want any PHI or identifier information. I just think if you would explain the situation a little bit more. You know, just – so just – again, just repeat what you said, you know, that your hospital took patients to the skilled nursing facility and you're getting these claims either to deny or recommend medical necessity, this is what you're including in the record and, you know, what else do we need.

I think we could kind of start to look into it from there and have some independent conversations then.

(Pamela Patrick): OK. And a quick follow-up question. Is there an ABN that is specific for ambulance service?

Connie Leonard: I do not believe there is ABN specific to ambulance. But if you want to add that into your e-mail, then we'll make sure that we get the proper answer from the ABN and ambulance expert.

(Pamela Patrick): OK, great. Thank you very much.

Connie Leonard: Thank you.

Operator: And again, if you would like to ask any question, press star one on your telephone keypad.

Your next question comes from (Rosemarie Joyce) of Eminent Medical. Your line is open.

(Rosemarie Joyce): Hi, good afternoon. I have one question on, if someone – another provider was transporting a patient and, say, we got called in for – and have to change the authorization, will we be able to notify our MAC that we would be the new provider or does it have to be the other one to, you know, end that authorization?

Connie Leonard: That's – it's a very good question and something they were actually been trying to work through. We expect to have more details in the implementation guide.

We certainly do not want to have situations where, you know, one supplier is – certainly there are situations where one supplier legitimately takes over for another supplier and this happen all the time. But as of who we need to get that from, I think, is still up in the air.

So we are working with our MACs. We're working with them on their operational processes and we expect to talk with them about this and get some more information out to suppliers in the implementation guide.

(Rosemarie Joyce): Perfect. Thank you so much.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (Todd O'Dell) from Lowcountry Billing. Your line is open.

(Todd O'Dell): Hi, thank you.

I actually – I have one more question but I'll try to keep it quick. My first question is, on the prior authorization request content, will there be any type of a form that we can use to fill out, or do we simply have to go by the outlined provided on what information is needed on the request?

Connie Leonard: There will not be a form per se depending on what states you're in. I believe – and Jennifer, correct me if I'm wrong, is that Novitas that has the local coverage determination or the LCD for non-emergency ambulance. And in that LCD, they do have some very specific documentation requirements that suppliers can follow.

And we do have that link to that LCD on our website. Palmetto GBA and South Carolina does not have an LCD, but certainly there are guidelines out there on Palmetto's website of that ambulance.

So, both of the MACs, when they're conducting their education, you know, they will discuss what is necessary for a claim to be medically necessary so I would certainly encourage all suppliers to participate in the appropriate education that's going to occur within your jurisdiction.

(Todd O'Dell): OK. One other question about the request that it needs to include the origin and destination of the transport with so when the approval comes through, would it only be approved for that origin and that destination, and then if the patient had to go somewhere else or from somewhere else, we have to get a separate prior authorization.

Connie Leonard: A separate prior authorization would not be necessary because what – and what would happen is in that 60-day period of time, there may be a few extra transport trips.

Then we're going with the assumption that someone who is going to dialysis, we need three trips a week. And that provides extra trip in that 60-day period of time that can be use for that beneficiary services.

Of course, if they were going for a dialysis but then they needed to go for a few wound care treatment or something else, those services, those transports can be use as long as they are medically necessary. So, if the origin changed one time or another, just because the beneficiary's circumstance is changed, a new request would not be necessary.

(Todd O'Dell): Great. That's all I need to know. One last question. Another thing it says, the request needs to include its documentation from the medical record to support the medical necessity.

When you think of the medical record, is it speaking of simply the run report or is it speaking of medical record in terms of the patient's full medical record provided by the patient's primary care physician or something like that?

Connie Leonard: You guys have great questions to talk to the MACs about when they do their educational record and really it depends on what states you're in to look at on their particular website as to what they have up there about what they feel is necessary to meet the medical necessity requirements.

The run sheet is certainly part of it, but it is not going to be everything that is going to be necessary because, again, from a Medicare perspective for – to qualify for the repetitive schedule of non-emergent ambulance transport, there are certain criteria, and those medical records are going to have to document that the beneficiary meets the criteria needed.

So I would suggest, you know, looking at the local coverage determination, if you're in Pennsylvania and New Jersey, or looking at the MAC's websites, and making sure you're signed up to get notifications as far as educational opportunities so that you can get more information from the MACs about what they're going to be looking at.

(Todd O'Dell): OK, thank you.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (Ely Sarkisian) from (Trans 8). Your line is open.

(Ely Sarkisian): Hi. I like to know if this service is going to be processed in Southern California.

Connie Leonard: No. The model currently is only in South Carolina, Pennsylvania and New Jersey.

(Ely Sarkisian): OK, thank you.

Connie Leonard: Thank you.

Operator: And there are no further questions at this time.

I will turn the call back over to the presenters.

Connie Leonard: Oh, we certainly appreciate everyone attending today.

We do expect to have one more special open door forum before the model would begin on October 30th in the State of South Carolina. And we will hopefully be able to have the implementation guide out there for the public to review and be able to kind of walk through this implementation guide.

In the meantime, if you have questions, please feel free to e-mail the prior authorization team here at CMS at [AmbulancePA@cms.hhs.gov](mailto:AmbulancePA@cms.hhs.gov) and we will definitely work to either incorporate that into our next open door forum or get back to you with the correct answer.

Thank you all. And have a wonderful afternoon.

Operator: And this concludes today's conference call. You may now disconnect.

**END**